

Harmony Heals, Inc



CONSENT FOR TREATMENT

Client Name: _____

Date of Birth: _____

Therapist: _____

I hereby authorize _____ to act in the capacity of therapist for counseling and psychotherapy.

I understand that all communication between my therapist and myself is both privileged and confidential, and cannot be discussed orally or in writing without my written consent.

Please note, as mandated under Californian law, the therapist is obligated to report any harmful or dangerous action the client intends to inflict on themselves or against another individual. Such actions include suspicion of child and/or elder abuse and suicidal tendencies and/or desires.

Signature of Client

Signature of Therapist

Print Name of Client

Print Name of Therapist

Date

Date